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No. 15-797

IN THE

Supreme Court of the United States

BOBBY JAMES MOORE,

Petitioner,

v.

TEXAS,

Respondent.

On Writ of Certiorari to the Court of Criminal Appeals of Texas

BRIEF OF INTERNATIONAL ORGANIZATIONS AND INDIVIDUALS INTERESTED IN MEDICAL EXPERTISE AND PSYCHIATRY AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

(*Amici* Listed On Inside Cover)

PAUL HESSLER
Counsel of Record
LINKLATERS LLP
1345 Avenue of the Americas
New York, NY 10105
(212) 903-9132
paul.hessler@linklaters.com

Counsel for Amici Curiae

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Amici Organizations

British Medical Association

Canadian Academy of Psychiatry and the Law

The Central Institute of Mental Health (Germany)

Charité - Universitätsmedizin Berlin (Germany)

College of Psychiatrists of Ireland

Donald Beasley Institute (New Zealand)

Irish Mental Health Lawyers Association

Mental Health Foundation (United Kingdom)

New Zealand Medical Association

The Royal College of Psychiatrists (United Kingdom)

World Psychiatric Association

Amici Individuals

Professor Kate Diesfeld (New Zealand)

Associate Professor Kris Gledhill (New Zealand)

Professor Lawrence O. Gostin (United States)

Dr. Anthony Kearns (Ireland)

Professor Harry Kennedy (Ireland)

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STATEMENT OF INTEREST

Pursuant to Supreme Court Rule 37, *Amici* respectfully submit this brief *amicus curiae* in support of Petitioner.[1]

Amici are academic, medical or scientific institutions, organizations, associations, institutes, foundations and individuals.

***Amici* Organizations**

BRITISH MEDICAL ASSOCIATION ("BMA"), founded in 1832, is the trade union and professional body for doctors in the United Kingdom. The association was initially established to create a "friendly and scientific" forum where doctors could advance and exchange medical knowledge. Following its transition into the BMA in 1855, its role expanded to become a professional body representing all medical practitioners. In this role, the BMA works with governments to lobby for improvements to health and health care. In addition it has established a research and publishing arm (for instance through its weekly journal, the British Medical Journal), in order to lead debate on key ethical, scientific and public health matters. Research conducted by the BMA often feeds into the development of new policy.

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[1] Pursuant to Rule 37.3, both parties have filed letters with the Court granting blanket consent to *amicus curiae* briefs.

Pursuant to Rule 37.6, *Amici* affirm that no counsel for any party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *Amici*, its members or its counsel made a monetary contribution to its preparation or submission.

CANADIAN ACADEMY OF PSYCHIATRY AND THE LAW ("CAPL"), is the national body representing psychiatrists in Canada with an interest in the field of forensic psychiatry. Its members and affiliates are psychiatrists and professionals in related disciplines who practice in the area of forensic psychiatry, including faculty at various academic institutions, fellows and residents. CAPL supports its members in the application of their scientific and clinical expertise to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters. Its members also have specialized expertise in the assessment and treatment of special populations, including young offenders, sexual offenders and violent offenders. CAPL promotes the advancement of clinical practice, education and research as they relate to forensic psychiatry.

THE CENTRAL INSTITUTE OF MENTAL HEALTH ("CIMH"), founded in Germany in 1975 as a model institution, is exemplary in successfully integrating innovative community patient care with state-of-the-art research and teaching in the field of psychiatry in partnership with institutions at home and abroad. A research institute of international acclaim and standing, it ranks among the three leading institutes of its kind in Europe. Across the entire spectrum of psychiatric disorders, the researchers at the CIMH conduct basic and clinical research to examine the ways in which mental illness occurs, develops and is most effectively treated.

CHARITÉ - UNIVERSITÄTSMEDIZIN BERLIN ("The Charité"), has a 300-year history of excellence in world-class medicine and research. The Charité is one of the largest university hospitals in Europe. All of its clinical care, research and teaching are delivered by

physicians and researchers of the highest international standard. The Charité lays claim to more than half of all German Nobel Prize winners in Physiology or Medicine.

The Department of Psychiatry and Psychotherapy at the Charité Campus Mitte comprises two sites, the Department of Psychiatry and Psychotherapy, Campus Charité Mitte and the Psychiatric University Hospital Charité at St. Hedwig Hospital. The Department of Psychiatry and Psychotherapy at Campus Mitte admits patients with all forms of psychiatric disorders including depression, borderline personality disorder, post-traumatic stress disorder and autism spectrum disorders. Professor Dr. med. Rainer Hellweg is Senior Consultant at the Department of Psychiatry and Psychotherapy at the Charité Campus Mitte and Head of the Forensic Psychiatric Expert Service.

COLLEGE OF PSYCHIATRISTS OF IRELAND, founded in 2009, is the professional, training and educational body for psychiatrists in the Republic of Ireland. The College of Psychiatrists of Ireland is the sole body recognized by the Medical Council of Ireland and the Irish Health Service Executive for the training of doctors to become specialists in psychiatry and for the continuing assurance of the career long competence of specialists in psychiatry. The College fulfils its mission through the education and training of psychiatrists, the provision of lifelong learning for psychiatrists, the advocacy for resources to support best practice in the delivery of mental health services, promoting best practice in education, training and research in psychiatry and providing public education in issues related to psychiatric illness, psychiatric services and mental health promotion.

DONALD BEASLEY INSTITUTE ("DBI"), was established in 1984 in Dunedin, New Zealand, and is recognized nationally and internationally as a leader in the field of intellectual disability research. The DBI was set up over thirty years ago in direct response to a lack of New Zealand research in the field of intellectual disability. Conducting and disseminating evidence-based and meaningful research continues to be central to the work of the DBI. Key research projects carried out by the DBI include the implementation of disability-specific legislation and policy in New Zealand and whether New Zealand, a signatory to the United Nations Convention on the Rights of Persons with Disabilities, has adequately considered and responded to the human rights and legal needs of people with intellectual disability.

IRISH MENTAL HEALTH LAWYERS ASSOCIATION ("IMHLA"), founded in 2007, is a membership composed of solicitors on the Mental Health Commission's legal representative panel and Mental Health Legal Practitioners and academics specializing in the area of mental health law. In addition to participating in the discussion on developments in the area of mental health law, the IMHLA also aims to encourage and maintain the highest standard of preparation, representation and practice in relation to mental health law. The IMHLA has previously made submissions to the Mental Health Commission in Ireland and to the government to challenge and clarify various aspects of proposed mental health legislation.

MENTAL HEALTH FOUNDATION, founded in 1949, works in the United Kingdom directly with people with mental health problems, learning disabilities and dementia, their families and services to help put policy into practice, carry out research and

development work and influence national and local policy.

NEW ZEALAND MEDICAL ASSOCIATION ("NZMA"), founded in 1886, is New Zealand's foremost pan-professional medical organization representing the collective interests of all doctors. The association's members come from all disciplines within the medical profession, and include specialists, general practitioners, doctors-in-training and medical students. The NZMA is a strong advocate on medico-political issues, with a strategic program of advocacy with politicians and officials at the highest levels. The key roles of the NZMA are: (i) to provide advocacy on behalf of doctors and their patients, (ii) to provide support and services to members and their practices, (iii) to publish and maintain the Code of Ethics for the profession and (iv) to publish the New Zealand Medical Journal.

THE ROYAL COLLEGE OF PSYCHIATRISTS ("RCPsych"), founded in 1841, is an independent professional membership organization, representing over 15,000 psychiatrists in the United Kingdom and internationally. The core purposes of the RCPsych are to set standards and promote excellence in psychiatry and mental health care; to lead, represent and support psychiatrists; and to work with patients, care-givers and other organizations interested in delivering high quality mental health services.

As a professional body, the RCPsych has a vital role in representing the expertise of the psychiatric profession to governments and other agencies. Public education is a core aspect of the RCPsych's activities; examples of its publications include the British Journal of Psychiatry, the BJPsych Bulletin, BJPsych Advances, Evidence-Based Mental Health, BJPsych Open and BJPsych International. Part of the

RCPsych's mission is to improve the scientific understanding of mental illness.

WORLD PSYCHIATRIC ASSOCIATION ("WPA") is an association of national psychiatric societies aimed at increasing the knowledge and skills necessary for work in the field of mental health and care for the mentally ill. It presently has 138 member societies, spanning 118 countries and representing more than 200,000 psychiatrists. The WPA organizes the triennial World Congress of Psychiatry, international and regional congresses and meetings, and thematic conferences. Its 70 scientific sections disseminate information and promote collaborative work in specific domains of psychiatry, including intellectual disability. It produces educational programs and book series, and developed ethical guidelines for psychiatric practice, including the Madrid Declaration (1996).

Amici Individuals

PROFESSOR KATE DIESFELD is a member of the California State Bar (inactive) and was a Staff Attorney at Protection and Advocacy, Inc. in Los Angeles. In England, she was Legal Supervisor of the Kent Law Clinic (Mental Health and Learning Disability) at the University of Kent. She also represented clients before the Mental Health Review Tribunal. She was Co-Chair of Auckland Disability Law's Advisory Committee. She is an Editorial Board Member of the Journal of Legal Medicine. She is co-editor of Involuntary Detention and Therapeutic Jurisprudence (2003, Ashgate) and Elder Law in New Zealand (2013, Thomson Reuters).

ASSOCIATE PROFESSOR KRIS GLEDHILL is an Associate Professor and Director of Clinical Legal Education at the Law School of AUT University, Auckland, New Zealand. He has published in the areas of criminal law, mental health law and human rights law. Before joining academia, he practiced in Virginia and then in England and Wales.

PROFESSOR LAWRENCE O. GOSTIN is University Professor at Georgetown University Law Center, where he is also the Founding O'Neill Chair in Global Health Law and the Faculty Director of the O'Neill Institute for National and Global Health Law. He is also Professor of Medicine at Georgetown University and Director of the World Health Organization Collaborating Center of Public Health Law & Human Rights. His books include Public Health Law: Power, Duty, Restraint (University of California Press, 2008) and Global Health Law (Harvard University Press, 2014).

DR. ANTHONY KEARNS is a consultant forensic psychiatrist in intellectual disability for the National Forensic Mental Health Service at the Central Mental Hospital, Ireland. He is also a clinical senior lecturer in forensic psychiatry of intellectual disability at Trinity College Dublin. Previously based in the United Kingdom for thirty years, he held posts as a consultant forensic psychiatrist in intellectual disability at the National Health Service and in the independent mental health sector. He has previously held honorary teaching posts at both the University of London and the University of Cambridge.

PROFESSOR HARRY KENNEDY BSc, MD, FRCPI, FRCPsych is Consultant Forensic Psychiatrist and Executive Clinical Director of National Forensic Mental Health Services at the Central Mental

Hospital, Ireland. He is also the Clinical Professor of Forensic Psychiatry at Trinity College Dublin. Professor Kennedy publishes extensively on psychiatric triage, routine outcome measurement, homicide, suicide, neuro-cognition, mental capacity and risk of violence. He has been called as an expert witness in many homicide cases and in human rights cases including 'slopping out' (prison conditions), marriage equality and pregnant prisoners. Professor Kennedy has also published a book on mental health law in Ireland.

STATEMENT OF THE CASE

For the purposes of this brief, *Amici* adopt the statement of facts in the Writ of Certiorari filed by Bobby James Moore and file this *amicus curiae* brief on behalf of Petitioner.

SUMMARY OF ARGUMENT

The Texas Court of Criminal Appeals' (the "CCA") deliberate application to Mr. Moore of an outdated and non-clinical definition of intellectual disability is contrary to the way in which the medical professions and legal systems in many non-U.S. jurisdictions[2] (the "Non-U.S. Jurisdictions") apply medical standards.

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[2] See authorities in Sections 1 to 8 summarizing the position in England, Canada, Australia, New Zealand, Ireland, Sweden, Germany and Japan, and authorities in Section 9 summarizing the position taken by the European Court of Human Rights. In addition, Counsel has reviewed the jurisprudence of a number of additional countries and found no support for the approach taken by the CCA. Those countries include: Belgium, France, Italy, Poland, Portugal, South Africa, South Korea and Spain. In many of these jurisdictions, the proposition advanced in this brief is considered obvious and therefore has not been explicitly addressed in jurisprudence.

As is to be expected, medical practitioners in the Non-U.S. Jurisdictions are ethically obliged to keep up-to-date with developments in their field and to apply current medical standards, techniques, and understanding in their practice of medicine. The logic underlying this obligation is self-evident. It would obviously be inappropriate for a patient receiving care for a longstanding injury to be treated with out-of-date medical techniques simply because such techniques were in use at the time that the injury was sustained. Counsel's review did not identify any jurisdictions in which medical practitioners were permitted to continue applying outdated medical standards.[3] On the contrary, such a practice would likely see the relevant practitioner disciplined for a serious breach of their ethical obligations. It is remarkable that the CCA chose to take an approach to the application of medical standards in a legal context that no member of the medical profession would be permitted to take in a medical context.

Medical standards are routinely used in many legal systems worldwide, particularly in the evaluation of expert medical evidence[4] and in the resolution of legal

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[3] For the avoidance of doubt, there is a necessary distinction to be drawn between applying a current medical standard (as the CCA refused to do and which medical practitioners are mandated to do), and deciding how a patient will be treated in any given scenario (assuming that there is a range of options which are all consistent with current medical standards), which is often necessarily influenced by a range of considerations, not least cost.

[4] Counsel's review of the jurisprudence of the Non-U.S. Jurisdictions indicates that the strength and reliability of expert medical evidence commonly depends, among other things, on the extent to which it is based on generally accepted medical standards in the relevant field or widely recognized guidelines and protocols.

disputes. However, Counsel's review of the jurisprudence on the application of medical standards in the Non-U.S. Jurisdictions did not reveal any instances of a statute, treaty or convention requiring the application of, or a court in such jurisdictions applying (deliberately or otherwise), outdated medical standards, tests or guidelines, nor any decisions, guidance or any other materials suggesting that it would be appropriate to do so.[5]

U.S. law and practice has, on occasion, been informed by the laws and jurisprudence of other countries and the international community, including in the context of the Court's Eighth Amendment jurisprudence.[6] On the basis of the propositions espoused in the statutes and case law identified in this brief, and given the facts of this case, the Court should consider the patent unreasonableness of the CCA's application of the outdated *Briseno* test in Mr. Moore's case.

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[5] With the obvious, and irrelevant, exception of the field of medical negligence where liability is necessarily assessed against the professional standards that prevailed at the time the liability arose (but not against a standard that had been superseded at the time the liability arose).

[6] *See, e.g.*, *Roper v. Simmons*, 543 U.S. 551, 575 (2005) (noting "the Court has referred to the laws of other countries and to international authorities as instructive for its interpretation of the Eighth Amendment's prohibition of 'cruel and unusual punishment'"); *Thompson v. Oklahoma*, 487 U.S. 815, 830 n.31 (1988) (noting "[the Court has] previously recognized the relevance of the views of the international community" in determining whether a punishment is cruel and unusual).

ARGUMENT

Huge strides have been made in medicine, and science more generally, over recent decades. Whenever developments occur and become widely accepted in the field of medicine, the medical professions in the Non-U.S. Jurisdictions rightly require their members to implement those developments and to apply such current standards in their practice of medicine. Such developments in medicine and science, frequently intersect with the law and, when such intersections occur, the courts must apply the most up-to-date medical standards on the relevant issue.

Contrary to the decision by the CCA, Counsel's review of the statutes, case law and procedural guidelines of the Non-U.S. Jurisdictions (which include both civil law and common law jurisdictions)[7] did not reveal any instance in which an outdated medical standard was relied on in the resolution of a disputed issue. Indeed, Counsel's wide-ranging review has not identified any statutes, treaties, conventions, case law or procedural guidelines which permit, encourage or even contemplate judicial disregard of accepted developments in medical knowledge in preference for abandoned medical standards.[8] The reason for this is obvious. Any court or system of justice that is applying a medical standard will benefit from applying the current standard; the quality of justice will inevitably be improved if it takes advantage of improvements in

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[7] The statutes and case law of many of the Non-U.S. Jurisdictions do not provide guidance specifically in the context of capital punishment, because many of them do not have capital punishment or do not actively use it.

[8] Again, with the obvious, and irrelevant, exceptions of the field of medical negligence and the necessary rationing of health care because of issues of cost.

medical understanding. Conversely, the risks that are consequent on relying on outdated standards speak for themselves.

It is generally considered self-evident (and not worthy of discussion) in many Non-U.S. Jurisdictions that a court should not apply an outdated medical standard. Notwithstanding this, there are many examples of statutes and cases demonstrating that the courts of certain Non-U.S. Jurisdictions are expressly required not to, or are not bound to, apply medical standards abandoned by the medical community.

In summary, the CCA's application of the now abandoned medical standard adopted in *Ex parte Briseno*, 135 S.W.3d 1 (Tex. Crim. App. 2004) is at odds with the ethical guidelines of the medical professions in the Non-U.S. Jurisdictions reviewed by Counsel. It is also at odds with the relevant statutes, procedural guidelines and case law of a number of Non-U.S. Jurisdictions, as demonstrated by the following jurisprudence, and is not supported by the jurisprudence of any of the other Non-U.S. Jurisdictions or any other guidance that Counsel has found.

1. England

All members of the medical profession in England are required to keep their professional knowledge and skills up-to-date, as mandated in guidance issued by the General Medical Council, the national public body which oversees and regulates the profession. General Medical Council, *Good Medical Practice*, ¶¶ 7-13 (2013), http://www.gmc-uk.org/static/documents/content/GMP_.pdf.

The British Psychological Society has published guidance for clinical psychologists who are required to determine whether an adult individual has an

"intellectual disability" under mental health and mental capacity legislation or for various purposes related to court proceedings. The Guidance expressly provides that psychologists must apply the criteria for determining "intellectual disability" that are set out in the most recently revised versions of the major classification systems (i.e., the American Association on Intellectual and Development Disabilities (AAIDD-11), the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders, DSM-5) and the World Health Organization (International Classification of Diseases, ICD-10)). The British Psychological Society, *Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood*, 12-15 (2015), http://www.rcpsych.ac.uk/pdf/ID%20assessment%20guidance.pdf.

Legal Sources

The English Court of Appeal (the second highest appellate court in England and Wales) has recognized that medical and scientific knowledge continue to evolve, and as such, "[a]s knowledge increases, today's orthodoxy may become tomorrow's outdated learning." *R v. Holdsworth* [2008] EWCA (Crim) 971, [57], [2008] All ER (D) 03 (Eng.). Courts should thus only apply medical standards that represent the prevailing view of the medical community.

In this regard, in a leading recent case on the issue of medical evidence, England's Court of Appeal held that prior appellate jurisprudence does not provide authority for a medical proposition and that the English courts are required to make decisions as to the application of medical standards based on an assessment of the evidence before them. *See R v. Henderson* [2010] EWCA (Crim) 1269 [6], [2010] All ER (D) 125 (Eng.); John Frederick Archbold, *Archbold:*

Criminal Pleading, Evidence and Practice ¶¶ 10-49 (P.J. Richardson ed., 1st supp., 64th ed., Sweet & Maxwell 2015). The court in *Henderson* noted that:

> It is trite to observe that the conclusion of any court as to the medical evidence, whether at first instance or on appeal, is dependent upon the evidence before that court. No appellate jurisprudence could provide authority for a medical proposition . . . Previous legal authority cannot determine whether the conclusion of a medical report should be accepted or rejected. The most legal authority can do is present an accurate record of what was or was not accepted or propounded.

Henderson, [2010] EWCA (Crim) 1269 at [6], 2010 All ER (D) 125.

2. Canada

In Canada, physicians owe a duty to treat patients in accordance with current and accepted standards of practice. Canadian Medical Protective Association, *Medical-Legal Handbook for Physicians in Canada* 16 & 21 (2016). They must promote best practices in response to changes in scientific knowledge. Federation of Medical Regulatory Authorities of Canada, *Physician Practice Improvement*, 3 (2016), http://fmrac.ca/wp-content/uploads/2016/04/PPI-System_ENG.pdf. In addition, practitioners are mandated to keep current with medical and health care developments. College of Family Physicians Canada, *Continuing Professional Development*, http://www.cfpc.ca/cpd/ (last visited July 31, 2016).

Canadian physicians also have a positive duty to seek out new evidence and knowledge, and to apply it in practice. For example, physicians in Ontario are

expected to be aware of current developments in their field, which includes maintaining an awareness of relevant practice guidelines and implementing them as appropriate. College of Physicians and Surgeons of Ontario, *The Practice Guide: Medical Professionalism and College Policies*, 14 (2007, revised online 2008), http://www.cpso.on.ca/uploadedFiles/policies/guides/PracticeGuideExtract_08.pdf.

More specifically, the Canadian Psychiatric Association recognizes a psychiatrist's ethical obligation to remain abreast of developments in psychiatry. Grainne Neilson, *Canadian Medical Association Code of Ethics Annotated for Psychiatrists* 2 (Ottawa: Canadian Psychiatric Association, 2002).

Legal Sources

The Supreme Court of Canada (the highest court in Canada) recognizes that medical and scientific knowledge is not frozen in time, but may evolve based on improvements to existing bases of knowledge. *See, e.g., R. v. Trochym*, 2007 SCC 6, [2007] 1 S.C.R. 239, ¶ 31 (Can.); *R. v. J.-L.J.*, 2000 SCC 51, [2000] 2 S.C.R. 600, ¶ 34 (Can.). The Supreme Court held that "even if [a technique or science] has received judicial recognition in the past, a technique or science whose underlying assumptions are challenged should not be admitted in evidence without first confirming the validity of those assumptions." *Trochym*, 2007 SCC 6, [2007] 1 S.C.R. 239, ¶ 32. Thus, in Canadian cases, a medical standard which was accepted into evidence in a past case may subsequently be found to be inadmissible due to the later invalidity of its underlying assumptions that once may have been considered valid.

Although the term "mental disorder" is a legal concept under the Canadian Criminal Code, R.S.C. 1985, c C-46 (applying at the federal level), it includes a medical component that evolves with the advancement of medical knowledge. *R. v. Simpson*, [1977] 35 CCC (2d) 33, ¶ 43 (Can. Ont.), rev'd on other grounds, *R. v. Swain*, 1991 CanLII 104, [1991] 1 S.C.R. 933 (Can.).

The application of up-to-date standards and techniques is, in certain circumstances, a statutory requirement of law. Under provincial workers' compensation regimes in Canada, for example, mental disorders must be diagnosed according to the "most recent edition" of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM"). *See, e.g.*, Workers' Compensation Act, R.S.B.C. 1996, c 492 (Can.); Workers' Compensation Act, R.S.A. 2000, c W-15 (Can.); Workplace Safety and Insurance Act, S.O. 1997, c 16, sched. A (Can.).

3. Australia

The Medical Board of Australia maintains a Code of Conduct which applies to all registered medical practitioners. The Code provides that practitioners must maintain and develop their knowledge, skills, and professional behavior, noting that professional development must continue throughout working life, "as science and technology develop and society changes." Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, ¶ 7.1 (2014), http://www.plasticsurgery.org.au/linkservid/DA7B6C84-CDCC-54EC-11FCF1515915CBD0/showMeta/0/. The Medical Board mandates continuing professional development, and a failure to satisfy the annual requirements can result in disciplinary pro-

ceedings, restrictions on the practitioner's registration, or a refusal to renew the practitioner's registration. *Health Practitioner Regulation National Law 2010* (ACT) s 38(1)(c) & (e) (Austl.)

Legal Sources

The High Court of Australia (the highest court in Australia) held that Australian courts are not bound by previously accepted medical evidence in the face of contrary medical standards and knowledge that prevail in the medical community. *See, e.g.*, *Timbury v. Coffee* (1941) 66 CLR 277 (Austl.); *Bull v. Fulton* (1942) 66 CLR 295 (Austl.). The High Court set forth this principle over seventy years ago in *Timbury v. Coffee*. In the context of determining whether a testator lacked testamentary capacity by reason of insane delusions, the court held that it was "not bound to go on applying views held over a century ago about mental disturbance and insanity and to disregard modern knowledge and understanding of such conditions." *Timbury*, (1941) 66 CLR at 284. The High Court emphasized this principle a year later in *Bull v. Fulton*, finding that "[i]t must be remembered . . . that some statements in [older judgments regarding mental diseases] are based on [then] current medical knowledge and that more is known about mental diseases now than then." *Bull*, (1942) 66 CLR at 339.

The High Court's view in *Coffee* was followed as recently as 2010 by the Supreme Court of New South Wales, in which the Supreme Court observed that "many reported cases contain judicial expositions of competency, and references in them to insanity, mental illness and delusions reflect the understanding of judges and in turn, medical opinion which changes from age to age." *Burgess v. Leech*, [2007] NSWSC ¶ 25 (Austl.).

4. New Zealand

The New Zealand Medical Association's Code of Ethics applies to all medical practitioners in New Zealand and is recognized as "the key source of advice on ethics for the medical profession." New Zealand Medical Association, *Code of Ethics for the New Zealand Medical Profession* 3 (2014). Principle 7 of the Code provides that practitioners must "[a]dhere to the scientific basis for medical practice while acknowledging the limits of current knowledge and contributing responsibly to innovation and research." *Id.* at 4. Doctors in New Zealand have an ongoing obligation to keep their knowledge and skills up-to-date and are required to complete continuing medical education on an annual basis in order to maintain awareness and understanding of current developments. Medical Council of New Zealand, *Good Medical Practice*, ¶ 83 (2016), https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf.

The New Zealand Psychologists Board maintains a Code of Ethics which is applicable to all clinical and counselling psychologists practicing in New Zealand. The Code provides that psychologists must be "able to justify their professional decisions and activities in light of current psychological knowledge and standards of practice." New Zealand Psychologists Board, *Code of Ethics for Psychologists working in Aotearoa / New Zealand* ¶ 2.2.4 (2012). Indeed, disciplinary action may be taken where a psychologist applies an outdated standard. *See, e.g.*, *In re Mr. S. HPDT* 188/Psy08/86P, 12 Nov. 2008 at [119] (N.Z.) (New Zealand Health Practitioners Disciplinary Tribunal decision suspending a psychologist for eighteen months, reasoning that the practice in question "might have been used in the psychotherapy context up to the

early 1990s, but it is not supported by recent evidence based research and literature . . . ").

Legal Sources

The Court of Appeal of New Zealand (the second highest appellate court in New Zealand), in the case of *SR v. R*, accepted that a trial court was entitled to prefer the evidence of an expert who had used the most recent version of an intelligence scale in assessing the accused's intelligence over the evidence of an expert who had used an outdated version. *See SR v. R*, [2011] NZCA 409, [2011] 3 NZLR 638. The Court of Appeal agreed with the trial judge that the use of an outdated version of the relevant intelligence scale by an expert giving evidence in the trial "cast immediate doubt on the validity of the assessment made by [that expert]." *See id*. at [148].

The New Zealand Court of Appeal has also emphasized the need for scientific experts to follow "recognised guidelines or protocols . . . " in giving expert opinion evidence. *See Shepherd v. R* [2011] NZCA 666, [2012] 2 NZLR 609 at [112]. That proposition is recognized in New Zealand's Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, which defines "intellectual disability" by reference to tests "generally used by clinicians . . . " for measurement of deficits in adaptive functioning. Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7(1) (N.Z.). In addition, the New Zealand Ministry of Health has established guidelines which are applicable to specialist assessors appointed for purposes of determining whether an individual has an "intellectual disability" under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. The Guidelines provide that "[t]he procedure is based on current clinical practice within New

Zealand . . . " New Zealand Ministry of Health, *Guidelines for the Role and Function of Specialist Assessors under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* 5 (2004).

5. Ireland

The leading textbook on the law of evidence in Ireland provides that in evaluating expert opinions, Irish courts will consider whether the views or methodology of an expert accord with those generally accepted in his or her field of expertise. Declan McGrath, *Evidence* 416 (2d ed. 2015); *see also People (DPP) v. Kelly* [2008] 3 IR 697 (Ir.).

6. Sweden

A peer-reviewed publication of the Swedish Medical Association provides that "as serious mental illness is a legal term, the medical conditions pertaining to the definition may vary over time." Jonatan Hedlund et al., *Svensk rättspsykiatri i förändring* [Swedish Forensic Psychiatry in Transition], Läkartidningen 2013; 110; CCAU. In accordance with this principle, the National Board of Health and Welfare ("NBHW") issues and updates instructions on the correct interpretation of "serious mental illness," with older instructions deemed outdated, and repealed, when updated instructions enter into force.

In a legal context, if a Swedish court doubts the conclusions drawn in a medical professional's psychiatric opinion, it may seek a second opinion from the NBHW. Inconsistencies between the two opinions are always resolved in favor of the NBHW so as to ensure that psychiatric opinions are always based on the most up-to-date versions of the NBHW's instructions. *Nytt Juridiskt* [NJA] [Supreme Court] 1998-03-24 p. 162 B3235-97 (Swed.), https://lagen.nu/dom/nja/1998s162.

Legal Sources

In Swedish courts, experts preparing psychiatric opinions are required to use standards set out in authoritative classification systems such as the ICD-10 (International Statistical Classification of Diseases and Related Health Problems) developed by the World Health Organization, and the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) drafted by the American Psychiatric Association. *See* section 4.3 *Socialstyrelsensförfattningssamling* [SOSFS] 1996:14 *Rättspsykiatrisk undersökning* [official publications by governmental department] (Swed.); *see also* Martin Borgeke, *Att bestämma påföljd för brott* [To determine the penalty for offense], 310-312 (*Norstedts Juridik AB*, Stockholm, 2 uppl. 2012) (Swed.) (explaining that experts preparing psychiatric opinions are required to apply the most recently revised versions of the ICD and the DSM).

Such standards undergo regular revisions and once such standards are translated and implemented, the new standards are applied by experts in Sweden. If such up-to-date standards are not complied with, a remark or ordinance may be issued by the Health and Social Care Inspectorate; alternatively, in more serious cases, the Health and Social Care Inspectorate may seek to revoke the license of the expert or medical professional in question. *See Socialstyrelsens information om diagnostiseringskoder* [National Board of Health and Welfare's information concerning diagnostic codes] (Swed.), http://www.socialstyrlsen.se/klassificeringochkoder/diagnoskodericd-10 (last visited Aug. 4, 2016); *see also Inspektionen för vård och omsorg* [Health and Social Care Inspectorate] (Swed.), http://www.ivo.se (last visited Aug. 4, 2016).

7. Germany

There is a wealth of support in German non-legal sources for the proposition that doctors and other medical practitioners must have regard to the most up-to-date medical standards when exercising their professional duties.

The Model Professional Code of Conduct for Physicians in Germany ("*Berufsordnung der Bundesärztekammer für die in Deutschland tätigen Ärztinnen und Ärzte*") states that conscientious practice of the medical profession requires "in particular . . . compliance with the accepted state of medical knowledge." 114th German Medical Assembly 2011 in Kiel as amended by the 118th German Medical Assembly 2015 in Frankfurt am Main, *(Model) Professional Code for Physicians in Germany*, 9 (2015), *translation at* http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/pdf-Ordner/MBO/MBO_EN_Novellierung_2015.pdf. The Further Training Regulations of the German Medical Association (*Fortbildungsordnung der Bundesärztekammer*) provide that further training for doctors should "impart knowledge of new scientific findings, new developments in medical procedure and medical technology" such as is "considered necessary to preserve and advance professional expertise." German Medical Association, *Bundesärztekammer Arbeitgsgemeinschaft der deutschen Ärztekammern* [Further Training Regulations of the German Medical Association], 2 (2013), http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/_Muster-_Fortbildungsordnung_29052013.pdf.

Separately, the German Social Code ("*Sozialgesetzbuc*h") stipulates that medical services provided by health insurance providers should "comply with . . .

the 'generally accepted state of medical knowledge' (*allgemein anerkannter Stand der medizinischen Erkenntnisse*) and must take into account . . . medical advancements." *Sozialgesetzbuch Fünftes Buch* [German Social Code Book V], § 2, ¶ 1. Moreover, reimbursement of the costs of medical treatment by health insurance providers is contingent on whether the treatment in question corresponded to the "current state of scientific knowledge" ("*jeweiliger Stand der wissenschaftlichen Erkenntnisse*"). *Qualitätsprüfungs-Richtlinie vertragsärztliche Versorgung des Gemeinsamen Bundesausschusses* [BAnz] [Quality Assessment Guideline for Statutory Health Insurance of the Joint Federal Committee] § 1 (Apr. 18, 2006) (Ger.), https://www.g-ba.de/downloads/62-492-16/RL_Qualitaetspruefung_2006-04-18.pdf.

Legal Sources

In Germany, an expert opinion used in courts is required to meet "approved scientific requirements" ("*anerkannte fachwissenschaftlichen Anforderungen*") and has to be prepared in accordance with the "current scientific state of knowledge" ("*aktueller wissenschaftlicher Kenntnisstand*"). *See Bundesgerichtshof* [BGH] [Federal Court of Justice] Nov. 12, 2004, 2StR 367/04, BGHSt 49, 347, 352 (Ger.); *see also* Axel Boetticher et al., *Mindestanforderungen für Prognosegutachten* [Minimum requirements for prediction expert opinions], *Neue Zeitschrift für Strafrecht* [NStZ] [New Journal of Criminal Law] 537, 539 (2006); Thomas Fischer, *Strafgesetzbuch mit Nebengesetzen* [Penal Code] § 20, ¶ 64b (63d ed. 2016). Furthermore, experts are required to continue their education ("*Fortbildung*") to the extent necessary to maintain and develop the competence required in practicing their profession and to be up-to-date with the current state of knowledge.

Press Release Nr. 03/12, 3. *Der Berufsverband Deutscher Psychologinnen und Psychologen e.V.* (BDP) [Professional Association of German Psychologists], *BDP nimmt Stellung zur Qualitätssicherung bei gerichtlichen Gutachten* [Comments on Quality Assessment of Judicial Expert Opinions] (Feb. 16, 2012), https://www.bdp-verband.de/bdp/presse/2012/03_gutachter.html.

8. Japan

Japanese physicians have a duty to keep abreast of medical knowledge and technology and to support the advancement of medical practices. Japan Medical Association, *Principles of Medical Ethics*, Principle 1, http://www.med.or.jp/english/about_JMA/principles.html (last visited July 28, 2016). Recognizing that modern medicine is "ever progressing," the Japan Medical Association's Ethical Guidelines for Physicians requires physicians to complete continuing education on a regular basis. Japan Medical Association, *2008 Ethical Guidelines for Physicians*, Japan Medical Association Journal vol. 52, no. 2, 75 (2009).

Legal Sources

The Supreme Court of Japan (the highest court in Japan) stated that when assessing the value of an expert opinion as evidence, such assessment should "tak[e] into account new findings and others from scientific and technological developments in later years as well." *See* Saikō Saibansho [Sup. Ct.] July 17, 2000, 54/6 SAIKŌ SAIBANSHO KEIJI HANREISHŪ [KEISHŪ] 550 (Japan).

9. European Court of Human Rights (the "ECtHR")

In a leading case on the detention of persons of "unsound mind" under Article 5(1)(e) of the European Convention on Human Rights,[9] the ECtHR acknowledged that psychiatric knowledge does not stand still. *See Winterwerp v. Netherlands*, App. No. 6301/73, Eur. Ct. H.R. (1979), http://hudoc.echr.coe.int/eng?i=001-57597. In *Winterwerp v. Netherlands*, the ECtHR held that the term "persons of unsound mind" as used in the Convention is "not [a term] that can be given a definitive interpretation . . . [its meaning] is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes." *See id.* at 401.

The ECtHR has referred to and relied on the principle set out in *Winterwerp* on numerous occasions. In *Hutchison Reid v. United Kingdom*, the court recognized that the grounds on which detention may be ordered under domestic law may change during a lengthy period of confinement, given that "considerable time has elapsed and medical, psychiatric and legal developments have, inevitably, occurred." *Hutchison Reid v. United Kingdom*, IV Eur. Ct. H.R. 1, 20 (2003). The ECtHR further acknowledged in *Rakevich v. Russia*, citing *Winterwerp*, that "psychiatry is an evolving field . . . " *Rakevich v. Russia*, App.

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[9] Article 5(1)(e) of the European Convention on Human Rights provides: "No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: . . . (e) the lawful detention . . . of persons of unsound mind . . . " European Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, E.T.S. 5.

No. 58973/00, Eur. Ct. H.R. at 30 (2003), http://hudoc.echr.coe.int/eng?i=001-61414.

In the case of *Radu v. Germany*, the ECtHR stated that the meaning of the phrase "a person of unsound mind" is "continually evolving as research in psychiatry progresses." *Radu v. Germany*, App. No. 20084/07 Eur. Ct. H.R. at 90 (2013), http://hudoc.echr.coe.int/eng?i=001-119678.

CONCLUSION

For the foregoing reasons, *Amici* urge the Court to reverse the judgment of the Court of Criminal Appeals of Texas.

Respectfully submitted,

PAUL HESSLER
Counsel of Record
LINKLATERS LLP
1345 Avenue of the Americas
New York, NY 10105
(212) 903-9132
paul.hessler@linklaters.com

Counsel for Amici Curiae

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